MID-TERM EVALUATION REPORT

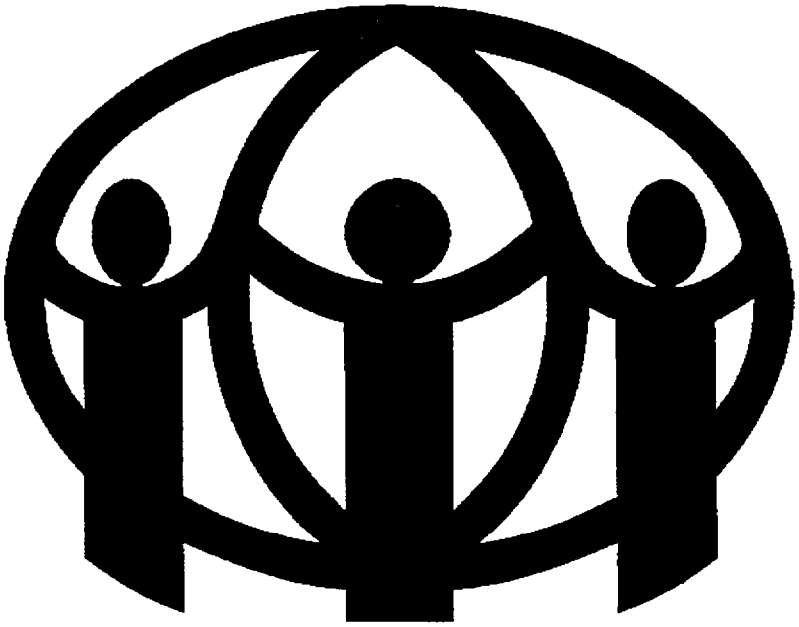
for

CHILD SURVIVAL VII

OTR #PDC-OSOO-A-00-%G7-00

1997

UGANDA



Submitted to

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C.

by

ADVENTIST DEVELOPMENT AND RELIEF AGENCY INTERNATIONAL
Silver Spring, MD

October 1993

CHILD SURVIVAL VII PROJECT

OTR #PDC-0500-A-00-1007-00

UGANDA

MID-TERM EVALUATION

1993 JULY 6-16

Evaluation Team:

Barry H. Wecker -- Independent Consultant, Team Leader

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
CBA	Child Bearing Age
CDD	Control of Diarrhoeal Diseases
CS	ChildSurvival
DIP	Detailed Implementation Plar
DMO	District Medical Officer
HIS	Health Information Systen
HP	Health Promote]
HT	Health Traine
ORS	Oral Rehydration Salk
ORT	Oral Rehydration Therapy
TOT	Training of Trainer!
TT	Tetanus Toxoic
UCBHCA	Uganda Community Based Health Care Association
VHC	Village Health Committee:

BACKGROUND OF THE PROJECT

Project Description

The Uganda Child Survival VII Project is a three-year project to improve the health o: mothers and children under five years of age in the Luwero District of south-central Uganda.

Project Funding

This project has been jointly funded by USAID and ADRA/Uganda.

Project Location

The project intervention areas are the two contiguous sub-counties of Kalagala and Zirobwe in Wabusaana County, Luwero District.

Reasons for the Choice of Project Location

This area was chosen for three reasons:

a) this area is one of the hardest hit areas of Uganda during the recent Uganda Civil War. There has been much loss of life, looting and destruction of property. At the peak of the war, the area was largely abandoned. Only recently has the population begun to return to their homes in this area.

This area lags behind other parts of Uganda in preventive health care; the populatior has below national average per capita earnings, sub-standard housing and poor wate supplies. The present government is aware of the problems in this area which is called the "Luwero Triangle" and has established a separate ministry which is responsible for the restoration of this area.

b) there were at the time the project started only two other NGO's which were working in the Luwero District--AMREF and MSF which were working in the northern part of the District. No other NGO's were working in Kalagala or Zirobwe Since the project has started, Plan International has also entered the area and is working with school rehabilitation.

c) ADRA's parent organization--the Seventh-day Adventist Church has operated an educational institution--Bugema College in Kalagala sub-county since 1948. It includes a primary school, a secondary school and a four-year college. Located on the campus of Bugema College is the only 24-hour medical service in the area-the Bugema College Dispensary and Maternity Center. It was felt that these institutions which are located at Bugema would be able to provide some logistical support to the project in this location.

Interventions
This Child Survival Project includes five interventions:

a) The immunization of children under one year of age
b) The control of diarrhoeal diseases and the promotion of oral rehydration therapy
c) Nutrition education and growth monitoring of children under five years of age
d) Family planning and child spacing
e) AIDS education

Goal and Objectives of the Project as listed in the DIP
The goal of the project is to increase the self reliance of families and communities by protecting mother and child health through improved delivery of basic health services, especially to under-fives, in one of the poorest and most disadvantaged areas of Uganda. In other terms to improve the health status of children and mother: through supporting various CS activities while seeking to develop cost recovery/income generation to help sustain all health gains.

The objectives of the project are:

a) To increase complete immunization coverage among the 12-23 month age group from 55% to 80%.

b) To increase the percentage of women of CBA who have had at least two TT immunizations from 40% to 70%.

c) To increase the percentage of mothers who use ORS (either cereal based or sachets) from 43.2% to 60%.

d) To decrease the percentage of children under five years of age who report to have had diarrhoea in the past two weeks from the present 46.3% to 45%.

e) To increase the percentage of homes which are growing kitchen gardens growing at least 5 kinds of vitamin and/or iron rich foods from 28.8% to 45%.

f) To increase the percentage of children under five who have been weighed at least once within the past 3 months from 34% to 60%.

g) To increase the percentage of couples who use modern methods of child spacing from 1.7% to 12% or more.

Project Methods
These interventions are to be promoted and carried out by:

a) the education and mobilization of the population of the two sub-counties
b) the training of 35 volunteer health trainers and about 700 volunteer health promoters who have been chosen by their communities who will then in turn work with their communities and especially the mothers and children of their communities to initiate and sustain health behavior changes.
c) the establishment of health committees at the sub-parish and sub-county levels.

Aims of the Evaluation
The purposes of the mid-term evaluation are:

a) to assess the progress of the project in attaining its objectives as outlined in the DIP at a point in time when the project is well-enough underway so as to be able to get an accurate idea of the direction that the project is taking but soon enough so that the project might be re-directed if it is seen to be slightly off target.
b) to assess the viability of the project.
c) to assess the long-term sustainability of the project.

It is with these in mind that the midterm evaluation was undertaken by:

Barry H. Wecker, M.D., M.P.H.-- Independent Consultant, Team Leader
Gerald Whitehouse, D.H.Sc., M.P.H. --ADRA International
Jaime Henriques-USAID Washington.

CHRONOLOGY OF THE PROJECT

1990 June		Idea of a Uganda Child Survival Project discussed with ADRA/Intemational and ADRA/Uganda.
1990 June to 1991 August	-	Project planning takes place
1991 August	-	New ADRA/Uganda Director arrives in country Project approved by USAID Proposed Project Period - 1991 October 1 to 1994 September 30
1991 August to 1992 March 1	-	Project put on hold by ADRA's Eastern Africa regional office in Harare, Zimbabwe
1992 February	-	Proposed Project director arrives in country

1992 March 1	-	Project authorized to begin by ADRA's Harare office
1992 March	-	Baseline survey organized by Lyndi Wolfe - ADRA/Intemational and Dr. Franco - Johns Hopkins University.
1992 April		Staff Workshop with staff from ADRA/International. DIP prepared
1992 June		DIP submitted to ADRA/International
1992 June		First Training Session for Health Trainers of Kalagala sub-county held by the Uganda Community Based Health Care Association.
1992 August	-	Second Training Session for Health Trainers of Kalagala sub-county also held by UCBHCA.
1992 November	-	Sharon Tobing from ADRA/International came and taught the staff how to run their own training session for Health Trainers--at the same time as the third Training Session for Kalagala Health Trainers.
1993 January	-	Sharon Tobing and Lester Wright from ADRA/ International hold final Training Session for the Health Trainers of Kalagala sub-county.
1993 April		First and second Training session of Health Trainers for Zirobwe sub-county
1993 June		Third and Fourth Training session of Health Trainers for Zirobwe sub-county
1993 July		Mid-term Evaluation

LIST OF CONTACTS AND PERSONS VISITED

Visit to the Uganda Ministry of Health

Persons Contacted:

Dr. Oryemebanyat	-	Assistant Director of Medical Service
	-	Maternal and Child Health
Dr. Fred Katumba	-	Maternal and Child Health Service

Visit to USAID/Uganda

Persons Contacted:

Mr. David Puckett	-	Health Programme Officer USA-ID/Uganda
	-	Technical Advisor for Child Survival

Visit to **ADRA/Uganda**

Persons Contacted:

Mr. Barry Chapman	-	Director of ADRA/Uganda
Mr. SSenteza	-	Assistant Director ADRA/U
Mr. Joseph Mayombwe	-	Coordinator of Health Projects ADRA/Uganda
Ms. Beverly Chapman	-	HIS Coordinator

Visit to the Child Survival Project Office

Persons Contacted:

Mr. Israel Musoke Sebakigye-Project Director
Ms. Annitah Namuyiga - Technical Advisor (EOP & CDD)
Ms. Deborah Saka - Technical Advisor (FP & Nutrition)
Mr. John Kiyimba - Training Officer
Mr. Laban Rutareberwa - Technical Advisor (Agriculture)
Ms. Ruth Wakabi - Secretary
Mr. Andrew Semambo - Supervisor - Kalagala Sub-county
Mr. Charles Musoke - Supervisor - Zirobwe Sub-county

Visit to the District Medical Office

Persons Contacted:

Dr. Stephen SSessanga Kaddu - District Medical Officer

Visit to PLAN/International

Persons Contacted:

Mr. Stephen Kadaali - Assistant Director

Miscellaneous

Persons Contacted:

Mr. Peter Gray - Regional Financial Operations Officer-

ADRA/Intemational
Project Trainers for Kalagala
Project Health Promoters (random)
Health Center Staff - Kalagala
RC-3 Health Committee Chairman - Zirobwe
World Vision Child Survival Programme Officer

1.0 ASSESSMENT OF ACCOMPLISHMENTS

At the time of the mid-term evaluation (July 1993) the Child Survival Project VII - Uganda had been operating for 16 months. The Project was approved and funding became available in October 1991, however the ADRA/Uganda office received instructions from its regional office in Harare, Zimbabwe that it was not to begin the project until certain financial details were clarified. This authorization was finally received on March 1, 1992. This delay of five months has put the project behind schedule.

MEASURABLE INPUTS

Baseline Survey
The Baseline Survey was conducted in February 1992.

Selection of Trainers
The selection of the Health Trainers was done during the month of March 1992. This was done in the following manner:

ADRA staff met with the two sub-county Resistance Councils (RC-3) and described ADRA and the proposed Child Survival Project to the community leaders. They asked them to select one person from each sub-parish who met the criteria necessary to be a trainer. 35 Health Trainers were thus selected by the various sub-parishes-16 in Kalagala and 19 in Zirobwe. 80% of the Health Trainers are men.

Selection of Village Health Committees
Village Health Committees were then selected by the communities--one for each sub-parish for a total of 32. These committees are composed of 11 members. The Health Trainer for that sub-parish acts as the secretary of this committee. 60% of the members of the Village Health Committees are women, 40% are men.

Training
An Orientation Seminar was held from 1992 March 26 to April 2 for the Child Survival Project Staff by Dr. W. Dysinger from ADRA/ International.

The Health Trainers in Kalagala have received 4 weeks of formal training; those of Zirobwe have received 3 weeks of training.

An outline of the training programme is as follows:

Training of Trainers Workshop I
Date: 1992 June
Location: Namugongo Retreat Center
Course Objectives:
1) Health and Development
2) Prevention and Cure
3) Concepts of Community Based Health Care and Preventive Health Care
4) Roles and Qualities of the Trainer, Village Health Committee and Health Promoter

Training of Trainers Workshop II
Date: 1992 October 11 - 16
Location: Namugongo Retreat Center
Course Objectives:
1) Effective Communication
2) Factors governing and affecting adult learners
3) Teaching Methods
4) Lesson Planning
5) Design a training workshop for Health Promoters

Training of Trainers (TOT) Workshop III
Date: 1993 January 27 to February 5
Location: Child Survival Project Office - Bugema
Course Objectives:
1) Presentation of the roles of the Health Trainer, Village Health Committee and Health Promoter
2) The role of the Health Promoter in EPI and CDD
3) How to conduct a census
4) How to conduct a training workshop for Health Promoters
5) How to support the Health Promoters-visits and feedback
6) How to get records and information from each Health Promoter

Training of Trainers (TOT) Workshop IV
Date: 1993 May 10 - 19

Location: Child Survival Project Office - Bugema
Course Objectives:

1) Methods and Importance of Child Spacing
2) Nutrition and Growth Monitoring
3) Kitchen Gardening
4) AIDS

The Training of Trainer Workshops for Zirobwe sub-county combined TOT I and TOT II and they took place on the following dates:

Training of Trainers Workshop I&II - 1993 April 14 - 23
Training of Trainers Workshop III - 1993 June 21 - July 1

Village Health Committee Training
A one day training seminar has been held for each Village Health Committee.

Bicycle Distribution
Each Health Trainer has been provided with a bicycle. Each Dispensary and Health Center has also been supplies with a bicycle to facilitate a vaccination outreach programme.

Borehole Rehabilitation
At the time of the mid-term evaluation 9 boreholes had already been rehabilitated.

MEASURABLE OUTPUTS

Persons Trained
As stated above, 35 Health Trainers have been selected--one from most sub-parishes and two from each of the three largest sub-parishes in Zirobwe sub-county.

The Health Trainers have mobilized their communities which have then in turn selected approximately 20 volunteer Health Promoters for each sub-parish.

The 316 Health Promoters in Kalagala sub-county have now been trained with regards to the first two interventions--Vaccinations and the Control of Diarrhoeal Diseases and training was in progress at the time of the mid-term evaluation with regards to the third intervention-Nutritional Education and Growth Monitoring.

In Zirobwe, 334 Health Promoters have been selected by the various sub-parishes and training was in progress at the time of the mid-term evaluation.

There was no data available as to the number of mothers who had received training, nor as to how much training or what type of training they had received. The reason for this is that the Health Information System is not at present providing this information except in an ad hoc manner.

OUTCOMES

Interventions

The five interventions of this project are:

a) Immunization of children under 1 and of women of child bearing age
b) Control of diarrhoeal diseases and promotion of Oral Rehydration Therapy
c) Growth Monitoring and Nutrition Education Promotion of Kitchen Gardens
d) Family Planning
e) AIDS Education

Of these five interventions only the first three have been started in Kalagala and only the first intervention is started in Zirobwe.

Intervention No. 1 -- Immunization

The outcomes of Immunization in Kalagala as of the end of May 1993 are as follows:

1) 291/1123 children or 26.7% of the children under one year of age have completed their immunization programme and an additional 796 children or 70% are on schedule but not as yet completed. If these figures are combined, 96.7% of the children under 1 year of age in Kalagala are on schedule for their vaccinations.

It should be noted however, that in order to get an accurate idea of vaccination coverage, a survey should be done to assess the number of children from 13-24 months of age who are completely vaccinated. This has not been done yet.

2) The second objective of the Project DIP states that the percentage of women of child bearing age who have received at least two doses of tetanus toxoid will be increased from 40% to 70%. The project has deviated from the DIP objective of vaccinating the women of child bearing age (15-49 years) but is vaccinating only the pregnant women. Of the 444 pregnant women in Kalagala, 269 women have received at least one dose of Tetanus Toxoid Vaccine-representing 60% of the pregnant women.

Either the DIP should be changed in order to reflect this change in the way in which the project is being done or the project should begin vaccinating all women of CBA and not just those who are actually pregnant. Because of this discrepancy, in order to get an accurate idea of the percentage of women of child bearing age that are vaccinated, a cluster survey would have to be done.

In Zirobwe, the immunization programme has just begun. The Health Promoters are just being trained in this intervention and as a consequence there is not data available yet.

Intervention No. 2 - Control of Diarrhoeal Diseases

The outcome of this intervention is not easy to assess. There have been no records kept of the number of women who have been trained in Oral Rehydration Therapy, the number of women who have used ORT for the treatment of their children with diarrhoea, or whether or not there has been a change in the incidence of diarrhoea in the community.

However when we questioned mothers and Health Promoters, they replied that all the mothers in their sub-parishes had been trained, that they were using Oral Rehydration Therapy and that the incidence of diarrhoea had decreased. This informal data needs to be verified through an improved HIS.

Intervention No. 3 - Nutrition Education and Growth Monitoring

This intervention has just been started in Kalagala. The registers of children under five years of age are in the process of being completed.

Intervention No. 4 - Familv Planning and

Intervention No. 5 - AIDS Education are scheduled to be initiated in the coming few months.

2.0 ASSESSMENT OF RELEVANCE TO CHILD SURVIVAL PROGRAMME

The major causes of child mortality and morbidity in Luwero District are:

a) Diarrhoeal Diseases
b) Malaria
c) AIDS
d) Acute Respiratory Infections
e) Intestinal Parasites
f) Malnutrition
g) Measles

The interventions of this project are:

a) Vaccination of children under one year of age and women of child bearing age
b) Control of Diarrhoeal Diseases and the promotion of Oral Rehydration Therapy
c) Nutrition Education and Growth Monitoring
d) Family Planning
e) AIDS Education

These interventions address four of the seven major causes of child morbidity and mortality in the project target area. The interventions that have been selected are in line with child survival intervention guidelines and address the priority issues

existing in the community. The interventions also provide an appropriate vehicle for infrastructural capacity enhancement in both the community for long term sustainability and in ADRA for more effective sustainable development programming.

3.0 - ASSESSMENT OF EFFECTIVENESS

The overall progress of the project in meeting stated objectives and yearly targets is appropriate if one takes into consideration that the project had a five month delay in starting.

The immunization programme in Kalagala is moving along well. Visits with the Medical Assistants at the various clinics have confirmed that measles is very rarely seen now. This intervention has been mildly hampered however, by an irregular delivery of vaccines from the District Medical Office in Luwero. This problem was discussed with the District Medical Officer who promised to try to improve the delivery system, but it is felt that improvement is unlikely. At the present time the project is providing the transportation for the vaccines from the DMO to the various health centers and dispensaries in the sub-county. This could present a problem for the long term sustainability of the project, however, this problem has been recognized and efforts are underway to address it. Another impedance to the vaccination programme is the distance that women must travel in order to have their children vaccinated. The project is working to solve this problem by the establishment of vaccination outreach programs in the various sub-parishes.

It is hard to assess the effectiveness of the Control of Diarrhoeal Disease Intervention due to the lack of appropriate data. This will be discussed further in relationship to the Health Information System.

There is evidence of excellent community mobilization. This is the vehicle by which the project will make its impact. It was felt however that more attention is need to the content of the community education programme. It is suggested that the project staff makes sure that the various “key messages” which are listed in the DIP for each intervention are being taught to the population of these two sub-counties in order to improve the effectiveness of the project.

4.0 - ASSESSMENT OF RELEVANCE TO DEVELOPMENT

The main community barriers to meeting the basic needs of children are as follows:

a) Poverty
b) Ignorance
c) Availability of Child Survival Services
   e.g. Vaccines, Oral Rehydration Packets, Contraceptives, Growth Monitoring centers etc.
d) Distance between homes and Child Survival Services

ADRA/Uganda is doing an excellent job of mobilizing the communities. The Health Committees at both the sub-county level (RC-3) and the sub-parish level are highly motivated and are very active. This was demonstrated by the presence of many of the committee members at the various intervention sessions that we visited. These committees are in need of problem-solving experience and further training. It will bc very important for the Health Trainers and the Sub-county Supervisors to keep in close contact with the Village Health Committees and the RC-3 Health Committees respectively, to provided them with information as to the progress of the project, ant to allow them to work at solving any problems that arise in the project. The Health Committees and the Resistance Councils are however, putting forth a great deal of effort to encourage the community members to participate in the various interventior activities.

This ADRA project has made an excellent beginning of fostering an environment which increases community self-reliance and they are making excellent effort as well in helping the community mothers better address the health and nutritional need of their families. Self-reliance is a long-term goal and the development of self-reliance takes many years to develop. It is a bit premature to expect a significant change at this early stage in the project. However, specific work needs to be done to build mutually interdependent linkages at the community level.

5.0 - ASSESSMENT OF COMPETENCE IN CARRYING OUT PROJECT

5.1 - ASSESSMENT OF DESIGN

The project has appropriately limited the size of its target population to that of two sub-counties-Kalagala and Zirobwe. The population of these two sub-counties is about 55,000 people- an appropriate population for the size of the project budget. Project activities began in Kalagala sub-county and has only recently expanded to Zirobwe sub-county. This represents an appropriate geographical development of th project. The experience that has been gained by the project staff in Kalagala will

permit them to make the necessary alterations so that many of the problems that they may have encountered in Kalagala may be avoided in Zirobwe.

The output and outcome objectives are appropriate, measurable and realistic.

Project strategies are generally considered to be appropriate for achieving the project objectives. The strategy for achieving the objective of TT immunization of women of child bearing age is an exception. Project should have chosen to target only pregnani mothers. The project apparently decided to change its target group because of difficulty in mobilizing the women of child bearing age. However, the Uganda Ministry of Health policy supports the objective of vaccinating the women of child-bearing age and it is recommended that if at all possible the project follow the strategy that was outlined in the DIP and begin expanding their Tetanus Toxoid Vaccination programme to include all women of child bearing age. If this is not possible or reasonable, then ADRA/Uganda will need to clearly defend its alternate strategy.

Unfortunately, one of the reasons for the slow start of the project was that this projec was designed from the "top down". Insufficient participatory "buy in" by local staff, particularly in the development of the DIP has contributed to delay in implementation of interventions since it took longer for the staff to get oriented to th project plan.

5.2 ASSESSMENT OF USE AND MANAGEMENT OF DATA (HIS)

The Health Information System (HIS) seems to be the weakest part of the entire Chill Survival VII Project in Uganda.

The first information to be collected was a census of the people in the two sub-counties. The census sheets are currently at the ADRA/Uganda office but so far they have not been entered into the computer or tallied. It has been found that man of the sheets have been incorrectly filled out and as such do not contain complete or accurate data. The person who has been assigned to enter this information into the computer is uncertain as to what to do with these sheets.

The basis of the Health Information System is a system of intervention-based registers. These registers are to be filled out by each Health Promoter who may or may not be illiterate. At the time of the mid-term evaluation the following registers were being used:

a) Register of Children under one year of age
b) Register of Pregnant Women
c) Register of Children under five years of age

It is quite possible that the following additional registers may perhaps be needed yet before the last intervention is finished:

a) Register of Women of Child Bearing Age (Family Planning)
b) Register of Children ages 6 - 12 years (AIDS Education)
c) Home Register (Kitchen Gardens)

In view of the education level of the Health Promoters, it is felt that there are too many registers. It suggested that one household register be kept on which all interventions are recorded. This would simplify the collection of data. If even this register is too complicated for the Health Promoter, it may have to be further simplified and more data may have to be collected from cluster surveys.

Up to the time of the mid-term evaluation, the only data collecting systems that have been used are:

a) Baseline survey
b) Initial census
c) Registers

The DIP plans for yearly census/surveys and occasional 30 cluster surveys. Up to the time of the mid-term evaluation these have not been done.

As the data collection system is re-evaluated and perhaps re-developed, it may be determined that some of the indicators need refinement or that the methods of data collection be changed. At present, the data collection system is too unmanageable to be able to make an assessment of the need to refine the indicators.

It has been suggested to the Project Director to visit other NGO's in Kampala that are involved with Child Survival Projects and to study their methods of data collection. Further technical assistance will likely be needed to develop a satisfactory HIS.

ADRA/Intemational is in the process of developing general guidelines for all its Child Survival projects which have HIS. This will include samples of the present HIS now in use.

5.3-ASSESSMENT OF COMMUNITY EDUCATION AND SOCIAL PROMOTION

The project has in its early stages focused on community mobilization and in this it has done well. It has now begun to shift its focus to health promotion. As the project begins to incorporate health promotion into its community mobilization, care will have to be taken to maintain an appropriate balance between these two aspects--to strengthen and maintain community mobilization but to remember that it is but a

means to attain the project objectives and a way to assure project sustainability. At the time of the mid-term evaluation, the health promotion aspect was still weak. The project director and supervisors are encouraged to clarify their health promotion objectives (the key messages as outlined in the DIP and in the UNICEF/WI-IO/UNESCO booklet "Facts for Life").

The provision of services has not been a direct part of the project so far. The immunization programme is being carried out by non-project personnel however the project has facilitated the provision of vaccination services by providing a bicycle to each health center for vaccination outreach programs and in fact the Kalagala Health Center has now three vaccination outreach programs in operation. They have also facilitated the vaccination programme by providing the transportation of the vaccines from the District Medical Office in Luwero to the Health Centers in Kalagala.

The project has not formally used any feed back mechanisms (focus groups, in-depth interviews) to get community input to develop, test and confirm its communication of key messages. No printed guidelines or training manuals are being used. This process appears to be rather ad hoc at this time.

The only service which was to be included in the CDD intervention was the distribution of ORS packets to the CDD promoter in each community. This has not been done up to now, with the focus being on home preparation using starch based rehydration solutions.

Growth Monitoring services were just beginning in Kalagala at the time of our visit.

There seems to be an appropriate balance so far among Community Mobilization, Service Provision and Health Promotion. The recommendation of the evaluation team in this regard is that the Health Promotion component needs to be strengthenec while at the same time continuing to develop the Community Mobilization.

Community information, education and communication were just starting to develop in Kalagala. The communication network is in place and the information is beginning to be communicated to the entire community. This was confirmed by all the medical and civic personnel that were interviewed. The communities have been discussing the information that is being taught and are also beginning to put this information into practice.

The messages that are being communicated are essentially the ones that are in the DIP. These messages are consistent with those that are being promoted by the Uganda Ministry of Health and the other NGO's in Uganda. They are standard Child Survival Messages. However, up to now it seems that the messages are not being clearly presented, that ADRA/Uganda has not put into place any monitoring

methods to assure that the messages that are getting to the mothers are consistent or are understood by the mothers. A substantial percentage of the mothers that were interviewed were not able to list the key messages and neither were the Promoters, Trainers or Supervisors. However when asked questions about specific key messages, most of the staff was able to answer well. In other words the content knowledge was good but the application of that knowledge in the form of "Here are the seven key messages for the control of diarrhoeal diseases" is lacking.

No printed material have been used up to the time of the evaluation. It of course should be recognized that according to the baseline survey 32% of the residents of this area are unable to read.

By and large the project has been quite creative in its approach to community education. We saw evidence of role-playing, songs, and group discussions, examples and individual participation as well as the lecture method of instruction. There has been no assessment of the effectiveness of community education however--the only evidence is anecdotal.

5.4 - ASSESSMENT OF HUMAN RESOURCES FOR CHILD SURVIVAL

The project is staffed with the following personnel:

Project Paid Personnel
- Project Director
- HIS Coordinator (Part time)
- 2 Supervisors - 1 for each sub-county
- 3 Technical Advisors
  - 1 - Vaccinations and CDD
  - 1 - Family Planning and Nutrition
  - 1 - Agriculture and Kitchen Gardens
- Training Officer
- Secretary
- 2 Drivers

Volunteer Personnel
- 35 Trainers
- 650 Health Promoters

The personnel are very capable and there is an adequate number and mix of staff to meet the technical, managerial and operational needs of the project. These staff are all Ugandans with the exception of the part-time HIS Coordinator.

All of the volunteers are multi-intervention workers. The DIP has called for the training of single-intervention workers in each community, however it seems to somewhat confusing to have both multi-intervention and single-intervention workers. The single intervention workers would have overlapping responsibilities with the multi-intervention workers and would have a much larger geographical area to cover which would entail having some form of transportation. Given the number of interventions, each community would have five single-intervention workers with a responsibility for 400 homes and fifteen multi-intervention workers with the responsibility of 20 homes each. This would present more difficulties in training and supervision. It is recommended that the project personnel evaluate closely their needs, the quality of work of the multi-intervention workers who are already trained and if they find that the quality of impact is adequate that they not train single-intervention workers.

Workloads appear to be reasonable although it does seem that the Health Trainers are kept quite busy. If this system is to be sustainable there must be some system developed in each community for the compensation of the health trainers. This has in fact been discussed with the various communities and 17/35 of them have already initiated income generating projects.

The Health Trainers have received 4 weeks of training in Kalagala and 3 weeks of training in Zirobwe. The initial 2 weeks of training for the Kalagala Health Trainers was done by the Uganda Community Based Health Care Association. This Association has been created by the Uganda Government specifically for training Community Health Workers. The training was a standard training and there was nc formal needs assessment done before the training began. It became evident to the project staff that the programme was helpful for health committee selection and training and community mobilization but inadequate for specific intervention implementation. Therefore ADRA/Intemational personnel did an on the job training session for the project personnel during the third training session which then enablec them to continue training the Health Trainers themselves. Therefore the training methodology was suited to the needs of the project and modified in the course of th training programme. The length of the training programme was appropriate. There was no testing of the Health Trainers to ensure that they had a certain level of understanding of the material that was presented. This is something that should be considered as a means of quality control.

Since the initial training, the Health Trainers are receiving informal continued training. This continuing education is not organized or planned at the present time.

In Kalagala Sub-county of the 16 Health Trainers--l2 are men and 4 are women. Th gender ratio was questioned and the evaluation team was assured by the staff that i did not seem to be a problem for the male trainers to relate to the female health promoters.

5.5 - ASSESSMENT OF SUPPLIES AND MATERIALS FOR LOCAL STAFF

The project has used very little printed, educational material. Most of the information that has been given to the Health Trainers has been given by word of mouth and then the relevant information has been transcribed into the individual trainer's notebook.

The use of more printed material would help the Health Trainers in their training of the Health Promoters. It would also be of considerable help in reminding the Health Promoters of the key messages that they need to teach to their communities and also ensure a greater uniformity of the information that is being given to the community. At present the local volunteer staff has virtually no material, supplies or equipment other than register sheets and scales for weighing children.

In view of the variability of literacy among the health promoters, it might be best to consider the development of a "Key Messages Chart" for each intervention using pictures or diagrams rather than just a written text.

It is suggested that a "library" of health promotion and health education materials be established at the project office which could then be used by the project staff for reference.

5.6 - ASSESSMENT OF QUALITY

The local project staff appear to be well trained. In discussion with the Health Promoters, they were able to give appropriate responses to questions about the interventions that they have been trained in. For example when we asked one Health Promoter how many "high risk' families she had among her 20 families, she replied that there were four. One lady was over 35 years of age and pregnant; another had more than 5 children; a third was under 15 and pregnant and the fourth was a single parent with three children.

However, if the Health Promoters and Health Trainers are asked to list the "key messages" for a particular intervention, they are unable to give a complete list. It was noted that both levels--Health Promoters and Health Trainers were better able tc correctly respond to questions of methodology than to questions of content. It is not that they do not know the content, but that the information is not organized and therefore has a tendency to be incomplete.

There has not however been any method of evaluation of how well trained the Health Promoters and Health Trainers are. It is suggested that some form of evaluation be done of both the Health Trainers and the Health Promoters to assess their level of understanding of the key messages.

The mothers are given excellent support and counsel by the local volunteer staff, whc are highly motivated. The interaction between the Health Promoters and the mother: is done by various teaching methods such as: listing expectations, question and answer discussion, small group discussion with reporting to the full group, sitting in a circle to facilitate participation.

5.7 - ASSESSMENT OF SUPERVISION AND MONITORING

The supervision and monitoring that takes place at the present time is as follows:

a) Health Trainer--Health Promoter

The Health Trainer visits each Health Promoter regularly on a monthly basis to collect a report of her activities for the month. In addition, the Health Trainer participates in as many of the Health Promoters activities as possible each month. It must be remembered however, than each Health Trainer has approximately 20 Health Promoters to supervise, so the time that he is able to spend with each one is limited. The supervision that takes place on this axis is limited to collecting reports, group meetings with the Health Promoters and periodic visits to the various health promotion activities in the various communities. It uses an ad hoc problem solving approach with no standard review of required activities.

b) Supervisor/Technical Advisor--Health Trainer

Once again the supervision of this axis is limited to periodic encounters and visit: report collection and visits to training sessions. The supervision is thus informal.

There does not appear to be any feeling on any level that there is inadequate suppor or supervision. The network of communication among the various staff and volunteers is excellent and everyone questioned affirmed that they had the necessaq support.

It is recommended however, that an organized system of supervision and support b developed. Each level should have some means of assessing the level of performanc of the next level. It is also recommended that a method of assessing the project!' impact in the community by developed.

5.8 - ASSESSMENT OF USE OF CENTRAL FUNDING

The administrative and technical support from ADRA/Uganda/International has varied in effectiveness and as a result the project has had a slow start. Some of the problems that were encountered are:

The expatriate personnel that were recommended to give guidance to the project were unfortunately lacking in medical and technical expertise and had no experience in Child Survival projects. They struggled along for a while but eventually they had to return home for medical reasons.

The project personnel were not involved enough with the preparation of the DIP. The DIP was written by a visiting consultant. The project staff consequently had difficulty understanding and working with a plan that was written by someone else. Had they been more involved with the development of the DIP, they would not have wasted as much time in trying to get oriented and starting out as they in reality did.

The initial training by the Uganda Community Based Health Care Association was focused on community mobilization not on how to begin implementing the interventions. Subsequently ADRA/International contracted with Sharon Tobing in November 1992 and Lester Wright and Sharon Tobing in January 1993 to assist ADRA/Uganda in beginning the implementation phase. It is generally felt among the project staff that Sharon's visits were the turning point in the project. They gave the staff the direction that was needed and the tools that they needed to get the project rolling.

In view of the fact that there is a great deal of similarity among Child Survival, it would seem appropriate for ADRA/Intemational to develop general implementation guidelines that would help the project staff of a new project get oriented and that would enable them to get the project rolling without delay. Attention must be given to involving staff in the application of these guidelines for each project both in the DIP preparation and subsequent technical assistance for implementation.

Funding is adequate and it is apparently arriving in time to meet the needs of the project.

It is felt by the project staff and the ADRA/Uganda office that the line item in the budget for per diem allowances for the Health Trainers during their training sessions would be more appropriately used for the creation of a revolving fund to help the various communities start some income generating activities. It is recommended by the evaluation team that authorization be given to ADRA/Uganda for this change in the budget. Guidelines will of course have to be developed for the use of these revolving funds.

5.9 - ASSESSMENT OF ADRA'S USE OF TECHNICAL SUPPORT

The main technical assistance to date has been:

1) DIP preparation
2) Training of Trainers by the Uganda Community Based Health Care Associatio

3) Training of Trainers by Sharon Tobing
4) HIS development by Sharon Tobing
5) Assistance with Project Management by Lester Wright
6) Regional AIDS conference

A 10 day Health Information Systems seminar was conducted by Sharon Tobing from ADRA/Intemational from 1992 November 19 to December 3. This is reported to be the most important technical advice to be given to the project to date.

Content of HIS Seminar

a) Key Messages which need to be communicated to a mother for each of the project interventions
b) Development of the types of registers to be used in following the mothers and children of the community.
c) Development of the home visiting guidance forms to be used by Health Promoters when visiting mothers in the community.
d) Development of the summary forms to be used by Health Trainers and the sub-county Supervisors for reporting activities.
e) Development of the census forms.

The project also used the Uganda Community Based Health Care Association for the TOT 1 and 2 session for the Kalagala Trainers. This went well, however the project staff felt that with some additional training that they would be able to conduct the remainder of the TOT sessions themselves.

The project urgently needs some further technical assistance in re-evaluating their Health Information System. The present HIS is cumbersome and is not well adapted to the needs of the project. It is not allowing the project to collect the information that would permit the project to assess its impact and make the necessary changes SC that the desired impact be achieved. Technical Assistance is also needed to work with the staff in developing the AIDS education component of the project. There seems to be sufficient funds for a consultant to assist with these technical needs.

5.10 ASSESSMENT OF COUNTERPART RELATIONSHIPS

The chief counterpart organization of the project is the Uganda Ministry of Health. There are several points where the project and the Ministry meet. These are:

1) DMO's office - The DMO is responsible to see that vaccines are delivered to eacl health center and dispensary in his district. This rarely occurs. When we met with the DMO, he stated that transportation was too uncertain to be able to guarantee a regular delivery of vaccines and a regular maintenance of the cold chain. Therefore,

at the time of our evaluation, it was project personnel and vehicles which were assuring a constant supply of vaccines and the health centers. This transportation is supposed to be reimbursed by the DMO's office, however there are problems with collecting the reimbursement as well.

The DMO is also supposed to provide family planning materials to each of the health centers and it is expected that the centers will have the same problems in maintaining a constant provision of contraceptives just as they currently have with vaccines.

It is recommended that the project staff work with the RC-3 Health Committees to attempt to find a way to resolve the problems with the DMO's office. Perhaps a joint effort by both RC-3's and representatives of local health committees could provide a forum with enough influence to effect change.

2) Health Centers - There is an excellent spirit of cooperation between the various dispensaries and health centers and the project. The health centers have received bicycles from the project to assist them in vaccination outreach programs in the outlying areas. The project depends on the health centers to provide the vaccinations and shortly the family planning services as well.

Some accountability, reporting, and functional linkages with the Health Centers need: to be developed however. For example, who will be responsible to see that all the sub-parishes are served by the vaccination outreach programme from the Health Center. The RC-3 Health Committee and the Health Trainer need to establish this relationship.

At the present time, the Ministry of Health is not able to take over the functions of the project and it is unlikely that they will be able to do so in the near future. The project must assist the communities to develop the necessary mechanisms to continue the child survival activities after the project ends with or without Ministry of Health support.

3) The RC-3/Health Management Committee needs to be worked with to understand their role in primary health care. They need help in analyzing their problems, deciding on appropriate solutions, prioritizing budget allocations, and taking general responsibility for health spending of their funds. For example in Zirobwe they are building an addition on their health center which they are not able to adequately operate with the existing buildings.

This RC-3/Health Management Committee is the place to build sustainability for such items as the supply of vaccines from the DMO. ADRA needs to be aware of all the players in the community level network, to begin to define roles and responsibilities as relates to sustainability of project interventions and with a longer

view to an integrated Primary Health Care Health Management Committee (Sub-County), Health Center (Sub-County), RC-1 and 2 (Village and Parish), Health Committee (Sub-Parish), Health Trainer, and Health Promoter.

4) The project seems to have good working relationships with the local Health Committees. Further work must be done to institutionalize Child Survival activities and linkages among these community entities.

Health Trainers and Health Promoters are very enthusiastic and their work output is high. However they must become linked with the other sustainable community entities.

5.11 - ASSESSMENT OF REFERRAL RELATIONSHIPS

The major components of the health care delivery system in Kalagala and Zirobwe are:

1) 3 Dispensaries and Health Centers
   a) Kalagala Health Center
   b) Bugema College Dispensary and Maternity
   c) Zirobwe Health Center
2) District Medical Office - Luwero
3) Referral Hospital in Kampala

Since the project is not involved in curative medicine, there is no need for extensive referral patterns for patients. The project has established excellent working relationships with the three health/centers/dispensaries of the two sub-counties. Since the project does not have any curative programs, patients who are ill are advised to consult with the medical assistant at any of the health centers.

Specific Child Survival intervention of this project which require referral are: a) Immunizations b)Sick children (dehydration, malnutrition) and c) Family Plannin Services. So far the only one that is functioning is the vaccination programme and it seems to be working well given the constraints which are mentioned above. At the local level as long as the vaccines are available the relationship seems to be working well. Further work will need to be done to enhance and formalize working relationships.

5.12 - ASSESSMENT OF PVO/NGO NETWORKING

There has been good cooperation between ADRA and the Uganda Community Base Health Care Association. This is a group which was organized by the Uganda Government to act as a coordinator for the different agencies which were involved with community health care. The first two Training of Trainer Sessions were put on

in conjunction with UCBHCA and since there has been a good working relationship with this group throughout the entire project.

The only other NGO organization that is working in Zirobwe and Kalagala sub-counties is PLAN-International. They have recently established an office at Luwero and have begun working in the area. At the time of the mid-term evaluation, no contact had been had with this organization although it was rumored that they were interested in becoming involved with the health care delivery system and perhaps even with child survival. A visit was arranged with PLAN-International when we visited Luwero. During this meeting, the ADRA-Child Survival Project Director described the project to the Associate Director of PLAN-International and there was expressed an interest in cooperation and non-duplication of effort. Further meetings are to be arranged with PLAN/International and ADRA/Uganda.

The other NGO's who are involved with Child Survival Projects in Uganda are: World Vision and AMREF. Contacts have been made with these two organizations and there is an effort to share materials and experience.

Two Child Survival Project staff members attended the recent workshop on AIDS hosted by World Vision/Uganda. ADRA/Uganda also regularly attends NGO coordinating meetings.

5.13 ASSESSMENT OF BUDGET MANAGEMENT

The budget appears to be an adequate budget and the project is working well within the budget. Due to the late start of the project, ADRA/Uganda is requesting a one year extension to the project with no extra funding. The project will be able to achieve its objectives with the remaining funding, however, due to the delayed start the additional one year time frame will be needed to achieve the objectives.

The budget is being managed in a fiscally responsible way and ADRA/Uganda appears to be adequately flexible in the management of the budget.

The only suggested change to the budget is as the change from per diem allowances for the Health Trainers during the training sessions to be used for the creation of a revolving loan fund for the communities that need a boost in starting income generative activities.

6.0 SUSTAINABILITY

The Project Staff (Director, Trainer, Sub-county Supervisors and 3 Technical Advisor: are the only paid personnel. The Health Trainers and the Health Promoters are volunteers who have been chosen by the communities. The Health Trainers are

required to spend a considerable amount of time with project activities and therefore some form of reimbursement should be provided for them. The need for some form of reimbursement has been discussed with the Village Health Committees and 17 out of the 32 Village Health Committees have already begun some income generating activity. These activities include crop cultivation (peas, capsicum, sweet potatoes, green peppers, beans, and maize), animal husbandry (cattle, poultry) and some communities are working with ADRA and Shell Oil/Uganda in the cultivation of pilipili (hot peppers). Shell Oil has agreed to provide the seed and guarantee the purchase of the peppers after they are harvested. There seems to be much interest in this project among the various communities.

The income that is generated from these activities is being used to help support the Health Trainers and also to help out the Health Promoters who are in difficulty. The money is being managed by the Village Health Committees. When asked if they were keeping their money in the bank-they replied that they were not. It is therefore recommended that some help be given to these communities in banking and money management so that they can earn interest on their money and then use their money wisely.

Several of the communities have had difficulties in finding enough money to begin their income generating activities. For this reason, ADRA/Uganda is suggesting thai a revolving fund be created so as to be able to loan some start-up money to these communities which would be repaid when their activity became profitable. (See Page 28)

The Supervisors have also recognized that they need to develop some form of incom generating activity so that their component of the project will become sustainable after the project is ended. They have also developed a revolving fund to enable ther to begin income generating activities and thereby reduce their dependance on projec salaries. The continued presence of these Supervisors is very important for the long term sustainability of the project.

ADRA/Uganda has developed this project so that it has a high degree of sustainability. The community is very interested that the Child Survival activities continue after the project has ended and they are actively involved with income generation.

The Ministry of Health supports the project in principle, but as yet they have not become overly involved with the project due to the fact that they are already functioning at the limit of their capabilities-largely in curative care, but definitely though to a lesser degree in preventive care as well.

The sustainability possibilities of this project lie within the realm of the RC-3 Health Committee and the Village Health Committees. A conununity network--an interdependent and mutually accountable network can be created between the RC-3 Health Committee, the RC's themselves, the Village Health Committee, the Health Trainers, the Health Promoter and the Health Centers. The Health Committee shoulc review reports from the Health Promoters through the Health Trainers. The Health Committee then should see that continued in-service training is provided to the Health Trainer and the Health Promoters. The Health Committee is also responsible for the incentives to the Health Trainers and Health Promoters. The services which can be sustained with this type of community based network could be:

a) Home management of diarrhoeal diseases
b) Referral to the Health Center of children at high risk of diarrhoeal disease
c) Vaccine supply
d) Vaccination outreach activities to the sub-parishes
e) Community level problem solving
f) Continued Health Promoter activity
g) Household registry
h) Follow-up of high risk households
i) Growth Monitoring/Nutrition Education activities
j) Kitchen garden promotion
k) Provision of local varieties of seeds
1) Family Planning education activities
m) AIDS education activities

By establishing such a community support network which can then link with existing MOH services, project activities should be sustained at the end of the project. Of course the local communities will have to continue working with the Ministry of Health in order to continue building these relationships.

7.0 RECURRENT COSTS AND COST RECOVERY MECHANISMS

The project managers are aware of the human, material and financial inputs required to sustain effective child survival activities. They are beginning to calculate the amount of money which will be needed to keep the project going after the end of the funding period, although it is still early enough in the project (due to the late start 01 the project) that many of these costs are still unknown. The community is gradually becoming sensitized to the financial requirement of continuing child survival activities, however they have less than one year of experience with the project and it will take at least another year for them to see the full benefit of the project and become aware of the cost of sustainability. They will need to begin planning for the continuation of this project during the next year.

The government is willing to continue to provide the vaccines for vaccinating children, maintain the cold chain, provide the vaccination and growth monitoring cards, provide the contraceptives for family planning and child spacing. These supplies will constitute a significant part of the recurrent cost of the child survival activities.

As indicated elsewhere, many of the village health committees have initiated various income generating projects. These need to be encouraged and guided so that in fact they do begin to feed into the support of child survival activities in the community.

ADRA/Uganda has also begun a project in conjunction with Shell Oil/Uganda in the cultivation of hot red peppers (pilipili). Shell Oil has been trying for some time to encourage the population of Uganda to increase their production of these peppers, however up to the present time they have not had the community mobilization necessary to do this. They have now requested ADRA to assist them and the cultivation of hot peppers as a cash crop has taken off. ADRA/Uganda will receive commission for their part in this project, while the individuals and communities which grow the peppers will receive cash for their crops. Shell Oil is guaranteeing th market for the peppers. This will not only assist the communities in income generation, but it will also help ADRA/Uganda to recover some of their administrative costs. This then, would have the potential for being institutionalized as a locally sustainable income project.

The costs which will not be sustainable in the long term are:

a) the costs that are involved with the operation of the three project vehicles. One of the vehicle has been donated by USAID and will be turned over the Ministry of Health at the end of the project.
b) the costs of the salary of the project director and perhaps even the cost of the salaries of the technical advisors.
c) the cost of office overhead, equipment and secretarial services

It is recognized that these costs may not need to be sustained if a truly community based, sustainable system which relates effectively to the MOH is achieved.

The whole question of recurrent cost and cost recovery will have to be addressed more closely during the second half of the project.

8.0 RECOMMENDATIONS

1. RECOMMENDED that ADRA/Uganda continue to seek funding for improving the water supply of the two sub-counties. Clean water is an essential component of child survival and it is a priority for all the communities that we visited.

2. RECOMMENDED that the title of the various types of personnel in the project be standardized. It seems that Health Promoter is the term that is currently being used in the project instead of Community Health Worker or Village Health Worker and that Health Trainer is being used instead of VHW Supervisor.

3. RECOMMENDED that ADRA/Uganda and ADRA/International re-evaluate the Health Information System and that it consider replacing the intervention-based registers with a one household, multi-intervention type of register. These family registers should include a way of identifying the high risk homes.

4. RECOMMENDED that the reporting from the Health Promoter be kept simple, involving only those parameters which are needed for the functional monitoring of the implementation. Impact indicator information can be obtained through cluster surveys periodically.

5. RECOMMENDED that cluster surveys be done as needed to assess the progress of the project in achieving its objectives. This is especially important in the interventions for which data is not collected by the Health Promoters and the Health Trainers i.e. Control of Diarrhoeal Diseases.

6. RECOMMENDED that the project re-evaluate its decision to provide Tetanus Toxoid Vaccines to the pregnant mothers only and not to all women of child-bearing age. In view of the Ministry of Health's policy of providing two doses of Tetanus Toxoid to all women of child bearing age, it is the recommendation of the evaluation team that strong consideration be given to following the MOH policy.

7. RECOMMENDED that more emphasis be put on the "key messages" for each intervention. This may be facilitated by the preparation and distribution of a list--either pictorial or written, so that each level of personnel would have these key messages available for reference.

8. RECOMMENDED that some method be established to evaluate whether or not the desired messages are actually reaching the mothers of the community. This coulc be done by a cluster survey and it could assess both knowledge and behavior change

9. RECOMMENDED that more use be made of printed material for both the Health Trainers and the Health Promoters such as training manuals.

10. RECOMMENDED that a library of health education materials be developed at the Project Office. These materials could be used as reference materials by the staff.

11. RECOMMENDED that the project continue to work with multi-intervention Health Promoters--each responsible for 20 homes rather than single-intervention workers who have a responsibility for 60 or 80 homes as indicated in the DIP. This will permit each Health Promoter to become well acquainted with each family and it: needs.

12. RECOMMENDED that a systematic programme of continuing education be organized for the Health Trainers and Supervisors.

13. RECOMMENDED that the line item on the budget for per diem allowances for the Health Trainers during the TOT workshops be changed to allow for the development of a revolving fund for income generating activities at the village level.

14. RECOMMENDED that efforts be made by the project personnel to work with the RC-3 Health Committees at building a better working relationship with the DMO's office. This would include solving the problems of the delivery of vaccinations and contraceptives to the various health centers and dispensaries in the region. ADRA needs to be aware of all the players in the community level network and to begin to define their roles and responsibilities as they relate to the sustainability of the project interventions. This will help them look towards an integrated Primary Health Care system. The community players that we see at present are:

a) RC-3 and RC-3 Health Committee (sub-county)
b) Health Center (sub-county)
c) RC-1 (village) and RC-2 (parish)
d) Village Health Committee (sub-parish)
e) Health Trainer
f) Health Promoter

15. RECOMMENDED that contacts be continue between ADRA and PLAN/International in Luwero. Good networking with all other PVO's in the area will promote a better development programme.

16. RECOMMENDED that ADRA/Uganda meet regularly with the other PVO's/NGO's who are involved with Child Survival in Uganda (World Vision, AMREF, etc.) so that experience can be shared.

17. RECOMMENDED that the project capitalize on the enthusiasm among the health committees by encouraging more formal linkages without stifling the ad hoc

enthusiasms. These could be making sure that monthly, quarterly and cluster survey reports are reviewed and discussed at the monthly meetings of the health committee and that the health committees begin to develop a supportive role to the Health Promoters.

18. RECOMMENDED that technical input be given to the Village Health Committees on income generation and money management.

19. RECOMMENDED that some accountability, reporting, and functional linkages be established with the local health centers. For example, some way of assuring that all of the sub-parishes are serviced by the vaccination outreach from the Health Center. The Village Health Committee and the Health Trainer need to establish this relationship.

20. RECOMMENDED that the RC-3 Health Committee continue to be worked with to help them better understand their role in primary health care. They need help in analyzing their problems, deciding on appropriate solutions, prioritizing budget allocation, and taking general responsibility for health spending of their funds. For example-the RC-3 Health Committee in Zirobwe is building a new Health Center while they are not able to adequately operate the existing center.

9.0 SUMMARY

The Mid-term evaluation of the Uganda Child Survival VII Project took place from 1993 July 6 - 16.

The Evaluators were:

a) Dr. Barry H. Wecker - Independent Consultant, Team Leader
b) Dr. Jerald Whitehouse - ADRA/Intemational
c) Mr. Jaime Henriques - USA-ID/Washington

Field Visits were made to the Uganda Ministry of Health, USAID/Uganda, ADRA/Uganda, Child Survival Project Office in Bugema and various field visits witl the Health Trainers, Health Promoters and Supervisors.

The project was six months late in beginning due to directives from the ADRA regional office in Harare, however a baseline survey has been done, staff have been oriented and trained, 35 Village Health Committees have been organized and trained 35 Health Trainers have been selected and trained with 4 training sessions in Kalagala and 3 in Zirobwe, 316 Health Promoters have been trained in Kalagala and 334 in Zirobwe. Two interventions have been introduced into Kalagala--Vaccination: and CDD and Growth Monitoring and Nutrition education has just begun. The Health Promoters are being trained in the first intervention in Zirobwe.

As of 1993 June 30, 26.7% of the children under 1 year of age in Kalagala have completed their vaccinations and another 70% are up-to-date for a total of 96.7% whc are vaccinated. 60% of the pregnant mothers in Kalagala have been vaccinated for Tetanus at least twice. All of the mothers in Kalagala have been educated about the control of diarrhoeal diseases and have been taught how to prepare ORT using cereal flour, salt and water. However we do not have accurate statistics yet on the number: of cases of diarrhoea or the number of times that the mothers have used ORT.

Strengths of the Proiect

The following aspects of the project were found to be exceptional:

a) quality of staff and their commitment to the project
b) community mobilization, organization, education and support
c) establishment of a sustainable programme

Weaknesses of the Proiect

The following aspect of the project were found to be needing additional technical support, re-organization and strengthening:

a) Health Information System including data collection, reporting and analysis
b) Clear understanding of the essential information that must be understood and taught for each intervention.

This project has gotten off to a slow start, however it is gathering momentum and headed in the right direction. It is well organized, adequately staffed and funded, and it has done an exceptional job at mobilizing the target communities. It needs to improve the transmission of key messages for each intervention and make sure that these are understood by the village mothers and it needs to improve on its data collection and reporting system.